

**Disregard all information in the paper application packet regarding fingerprinting!**

**If you anticipate having your fingerprints received by the Board office after January 1, 2013 do not use a paper fingerprint card. You must use the electronic fingerprinting process described in the following pages and must send the last confirmation page to the Board office.**

**If you have not sent in your application, you may reduce the application fee by \$43.00**

**The Livescan service provider will charge you directly when you submit your fingerprints at the Livescan service provider's place of business.**

**Electronic Fingerprinting**

Effective January 1, 2013, applicants for initial licensure must use a Livescan service provider to submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to the applicant. The results of the search will be returned to the Care Provider Background Screening Clearinghouse and made available to the Department for consideration during the licensure process. The fingerprints submitted by the applicant will be retained by FDLE and the Clearinghouse. Effective January 1, 2013, DOH will not accept fingerprint cards. All costs for conducting a criminal history background screening are borne by the applicant.

Because of this change, the current Originating Agency Identification (ORI) numbers will no longer be in effect after December 31, 2012. It is important to use the correct ORI number when submitting fingerprints. If you do not provide an ORI number or if you provide an incorrect ORI number to the Livescan service provider, the Board office **will not** receive your fingerprint results.

Applicants can use any FDLE approved Livescan service provider to submit their fingerprints. The applicant is fully responsible for selecting the Livescan service provider and ensuring the results are reported to the Department. For more information, FAQs and a list of all approved Livescan service providers please visit the Department's website at: [www.floridahealth.gov/licensing-and-regulation/background-screening/index.html](http://www.floridahealth.gov/licensing-and-regulation/background-screening/index.html)

# Electronic Fingerprinting

Take this form with you to the Live Scan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at:  
[www.floridahealth.gov/licensing-and-regulation/background-screening/index.html](http://www.floridahealth.gov/licensing-and-regulation/background-screening/index.html)
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**;
- The ORI number is available from the board office for the profession in which you are seeking temporary licensure;
- Typically background screening results submitted through Livescan service providers are received by the Board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Aliases: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
(MM/DD/YYYY)

Citizenship: \_\_\_\_\_ Race: \_\_\_\_\_ (W-White/Latino(a); B-Black; A-Asian;  
NA-Native American; U-Unknown)

Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
(M=Male; F=Female)

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Transaction Control Number (TCN#): \_\_\_\_\_  
(This will be provided to you by the Live Scan Service provider.)

Keep this form for your records.

## **FLORIDA DEPARTMENT OF LAW ENFORCEMENT**

### **NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE**

#### **NOTICE OF:**

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation,  
Criminal Justice Information Services Division

Privacy Statement

**Authority:** The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

**Social Security Account Number (SSAN):** Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

**Principal Purpose:** Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI( may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

**Routine Uses:** The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law , treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

**Additional Information:** The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

## Confirmation of Receipt

Name: \_\_\_\_\_ File # (if known) \_\_\_\_\_

Profession: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(MM/DD/YYYY)

Other last names: \_\_\_\_\_

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

☐ Yes ☐ No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(MM/DD/YYYY)

**Please send this form with your application and fees to:**

Board of XXXXXXXX  
P.O. Box 6330  
Tallahassee, FL 32314-6330

**If you send this form separate from your application please mail it to:**

Board of XXXXXXXX  
4052 Bald Cypress Way  
Bin # C0X  
Tallahassee, FL 32399-325X

Please remember If you have not sent in your application you may reduce the application fee by **\$43.00**



## TEMPORARY LICENSE FOR SPOUSES OF ACTIVE DUTY MEMBERS OF THE ARMED FORCES APPLICATION

**Mailing Address for Application and Fees:** P.O. Box 6330 | Tallahassee, FL 32314-6330, 850-488-0595

**Fees:** Application Fee - \$65.00 (non-refundable) | Background Screening Fee - \$43.00 (non-refundable)

### INSTRUCTIONS

Keep these instructions and a copy of the completed application, for future reference.

All questions must be answered in order to complete the form in its entirety. Failure to do so will cause the application to be incomplete and you will be requested to complete any missing questions or pages, as applicable.

If you need to explain or clarify any question or if any of the sections in the application do not contain sufficient space for the requested information, attach the additional information to the application.

### REQUIRED DOCUMENTATION

- 1. APPLICATION FORM AND FEES:** The application must be completed in full. Attach the cashier's check or money order made out to the Department of Health for \$108.00 to page 1 of the application.
- 2. PROOF OF MARRIAGE:** Proof of marriage must be provided to verify marriage to a member of the Armed Forces of the United States who is on active duty in Florida.
- 3. LICENSE/CERTIFICATE VERIFICATION:** Verification must be received to establish an active license, certification or registration for your profession issued by another state, District of Columbia, or possession or territory of the United States. This verification must include information that indicates that your license is not the subject of a disciplinary proceeding. You will not qualify for this license if you have been or currently are the subject of disciplinary proceedings in any jurisdiction in which you hold a license to practice a profession regulated in Florida under chapter 456, Florida Statutes.
- 4. OFFICIAL ACTIVE DUTY MILITARY ORDERS:** A copy of military orders showing your spouse is assigned to an active duty station in Florida.
- 5. PROOF THAT YOU ARE ENTITLED TO FULL LICENSURE:** You must submit the full licensure application for the profession in which you are seeking temporary licensure along with any supporting documentation required by that application. Documentation that is required for both applications, such as license verifications, are only required to be submitted once. *Full licensure application fees are not required for temporary licensure.*
- 6. TWO COMPLETE FINGERPRINT CARDS:** *(Second set is optional, but if one set of fingerprints is found to be incomplete, this may cause a delay in obtaining the license)*  
To request fingerprint cards please visit <http://www.fldoh.sofn.net/>. This website is designed to allow Florida Department of Health-MQA Candidates a means to register their demographic information and the option to purchase FD258 fingerprint cards to process their fingerprint-based criminal history background screening checks in accordance with Florida law.

TEMPORARY LICENSE FOR SPOUSES OF ACTIVE DUTY  
MEMBERS OF THE ARMED FORCES APPLICATION

**To Register:**

1. ENTER personal demographic data required to submit fingerprints.
2. OPTION to purchase FD 258 fingerprint cards.
  - If you choose not to purchase fingerprint cards you must make sure the police department or agency you choose to roll your fingerprints uses an FD 258. If the FD 258 is not used the fingerprints will not be accepted. You will be required to submit another set and your application will be delayed.
3. PAY: If fingerprint cards are purchased.
  - \$4.00 for regular USPS mail
  - \$10.00 for priority mail

OBTAIN RECEIPT generated online. Print the Bar Code Receipt and mail it to the address listed on the receipt with the completed fingerprint cards.

**7. NATIONAL PRACTITIONER DATA BANK (NPDB):**

**National Practitioner Data Bank Report** - Applicants are required to complete a self query to the NPDB and upon receipt of the query, provide the board office with a copy. A fee is charged to furnish this information. For more information, please visit the [NATIONAL PRACTITIONER DATA BANK](#).

You may contact NPDB at  
NPDB  
P.O. Box 10832  
Chantilly, VA 22021  
(800)767-6732

Once you receive your report, forward it to the board office address provided on the full licensure application.

***ADDITIONAL INFORMATION***

**WITHDRAWAL OF APPLICATION**

If you decide to withdraw your application, you must make the request in writing. The request must be received prior to the granting of licensure. The fees are non-refundable.

**ADDRESS CHANGES**

Please notify the board office immediately of any address change.

**FOR DENTISTS ONLY**

An applicant who is issued a temporary professional license to practice as a dentist must practice under the indirect supervision, as defined in s. 466.003, of a dentist licensed pursuant to ch. 466, Florida Statutes.

**Where to send the applications and attached cashier's check or money order:**

Florida Department of Health  
P.O. Box 6330  
Tallahassee, FL 32314-6330

TEMPORARY LICENSE FOR SPOUSES OF ACTIVE DUTY  
MEMBERS OF THE ARMED FORCES APPLICATION

**Personal Information** *LIST YOUR FULL, LEGAL NAME AS IT SHOULD APPEAR ON YOUR LICENSE*

**LICENSE PROFESSION/TYPE** (e.g., RN, Dental Hygienist): \_\_\_\_\_

**NAME:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_ (Apt. #) \_\_\_\_\_  
(Mailing address will display on the Internet if you have not provided a practice location address.)

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Country:** \_\_\_\_\_

**WORK NUMBER:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ **HOME NUMBER:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**NAME OF SPOUSE:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

**SPOUSE'S BRANCH OF SERVICE:** \_\_\_\_\_

**SPOUSE'S DUTY STATION:** \_\_\_\_\_

**DATE DUTY BEGAN OR WILL BEGIN IN FLORIDA:** \_\_\_\_/\_\_\_\_/\_\_\_\_ *Contact the board office if this date changes.*

**CORRESPONDENCE VIA E-MAIL:** By checking "yes" you are agreeing to allow the Department to contact you with information regarding your application via email. If you choose this option please check your email account frequently and notify the Department of any change to your email address. Print legibly.

☐ **YES** ☐ **NO E-mail Address (optional):** \_\_\_\_\_

**Name Changes**

List any name you have been known by:

\_\_\_\_\_  
\_\_\_\_\_

**Licensure/Certification Data**

List a current license, certification or registration for your profession issued by any state, District of Columbia, or possession or territory of the United States that you are using to obtain this license.

State	License Type	License Number	Original Issue Date	Expiration Date



# TEMPORARY LICENSE FOR SPOUSES OF ACTIVE DUTY MEMBERS OF THE ARMED FORCES APPLICATION

## History

- |   |   |
|---|---|
| 1. Have you ever been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession? | <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>  |
| 2. Have you ever had a health care provider license revoked or suspended?   | <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>  |
| 3. Have you ever been reported to the National Practitioner Data Bank?  | <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>  |
| 4. If your answer to question 3 was yes; Have you successfully appealed to have your name removed from the National Practitioner Data Bank?                               | <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>  |
| 5. Have you previously failed the Florida examination required to receive a license to practice the profession for which you are seeking a temporary license?             | <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b><br><input type="checkbox"/> <b>N/A</b> |

**NOTE: any reply of "yes" may result in denial of issuance of a Temporary License in accordance with Florida Statute 456.024(3)(h)**

## Application Checklist

- |       |  |
|-------|--|
| _____ | Completed temporary license application. <i>All questions <u>must</u> be answered. If a question is not applicable, mark it with N/A. Questions left blank will delay the licensure process.</i>                                       |
| _____ | Required \$113.00 fee payable by cashier's check or money order.   |
| _____ | Proof of current marriage to a member of the Armed Forces of the United States.  |
| _____ | License verification for the license listed in the Licensure/Certification Data section on page 3.   |
| _____ | Copy of official active duty military orders as proof that your spouse is currently assigned to a duty station in Florida.   |
| _____ | Two (2) fingerprint cards. <i>Failure to submit fingerprint cards will delay your application. (Second set is optional, but if one set of fingerprints is found to be incomplete, this may cause a delay in obtaining the license)</i> |
| _____ | NPDB report. <i>Applicants are required to complete a self query to the NPDB and upon receipt of the query, submit a copy of the report as part of this temporary licensure application process.</i>                                   |
| _____ | Completed full licensure application for the profession in which you are seeking temporary licensure along with any supporting documentation required by the application.  |

## Statement of Applicant

I declare these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.0083 and 775.084, Florida Statutes.

I hereby authorize all hospital(s), institution(s) or organization(s), personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign), to release to the Florida Department of Health any information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license to practice in the State of Florida.

\_\_\_\_\_  
Signature of Applicant (required)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed (required)

TEMPORARY LICENSE FOR SPOUSES OF ACTIVE DUTY  
MEMBERS OF THE ARMED FORCES APPLICATION

**CONFIDENTIAL AND EXEMPT FROM PUBLIC  
RECORDS DISCLOSURE\***

**Florida Department of Health**

**Application for**

**Temporary License for Spouses of Active Duty  
Members of the Armed Forces**

**Name:** \_\_\_\_\_  
                                    **Last**                                    **First**                                    **Middle**

**Social Security Number:** \_\_\_\_\_

\* This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USC § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

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*Mission: Protect and promote the health of all residents and visitors in the state through organized state and community efforts, including cooperative agreements with counties*